Local Health Improvement Plan

Carroll County, Maryland

2021-22

Carroll County Health Department

Public Health
Prevent. Promote. Protect.

The Partnership for a Healthier Carroll County

I. Introduction

Carroll County's Local Health Improvement Plan (LHIP) is a framework for local action to advance the vision of the Carroll County Health Department, ***A safe and healthy community for all.*** We can't achieve this vision without the help of many community partners and county residents. Like Carroll Hospital's Community Benefit Plan, this LHIP framework includes the needs of Carroll County residents, as assessed in the Community Health Needs Assessment (CHNA), as well as public health-related areas of focus and data from the Maryland State Health Improvement Process (SHIP).

The LHIP incorporates the priorities as determined by the Local Health Improvement Coalition/Access to Health Leadership Team, a diverse group of community partners. It also highlights the work of many agencies and groups, and calls upon the community to work together to reach our shared vision.

Carroll County's LHIC is uniquely tied to The Partnership for a Healthier Carroll County. The Partnership's Board served as the LHIC for several years and hosted LHIT (team) meetings at every other meeting of their Access to Health Care Leadership Team. Currently, the LHIC is combined with The Partnership's Access to Health Leadership Team (LHIC/AHLT), which meets quarterly and focuses mainly on gaps, barriers, and other issues impacting health care access in our community. Many meetings feature a speaker or panel on a current priority health topic, as well as time for agency updates and cross-agency problem-solving.

The Partnership's other leadership teams, Advancing Health and Wellness and Healthy Aging, use data indicators and engage community partners in addressing many of the chronic disease priorities in Carroll County.

Carroll County's Behavioral Health priorities are addressed by other groups as well, such as the Behavioral Health Advisory Committee (BHAC) and Opioid Senior Policy Group. The Partnership's C.A.R.E. (Carroll Anti-Stigma Resiliency Effort) Committee addresses the stigma surrounding mental health issues and treatment.

Carroll County's Cancer Coalition joined with the LHIC in 2017, in order to increase awareness of cancer-related issues in the county.

Leadership from the Health Department, the hospital, The Partnership, Carroll County Government, and our local integrated health care clinic for low-income and uninsured residents, Access Carroll, meet bi-monthly for Population Health Governance meetings, where many issues are discussed at a management and agency level. Issues raised at the LHIC that require more high-level agency collaboration may be further discussed at this meeting.

Members of the LHIC/AHLT include representatives from the Health Department, the hospital, and The Partnership; Carroll County Public Schools, the Carroll County Department of Social Services, and Carroll County Government's Citizens Services and other divisions as needed; the community action agency Human Services Programs, Inc.; regional managed care organizations and Health Care Access Maryland representatives; and several other local non-profits and human service agencies, as well as individual citizens, many of whom served on the Cancer Coalition.

The LHIC/AHLT is chaired by the Health Officer and the Executive Director of The Partnership. The Health Department's Health Planner and a Health Educator assisting with the planning and management of meetings, in addition to coordinating data collection and reporting with the Health Department's epidemiologist.

In late 2018 and all of 2019, the LHIT/AHLT reviewed community health priorities identified through an LHIP data review. This process is described in more detail, below. Before the LHIP was finalized, however, the COVID-19 pandemic began, and the Health Department was completely focused on pandemic response. In 2020, during the ongoing pandemic, the Maryland Community Health Resource Commission (MCHRC) funded LHIC redesign grants for each jurisdiction in Maryland, with the goal of growing and strengthening these critical community health planning groups. The funding supported the development of a charter, roster, and public presence, reflecting increased community engagement with diverse groups. It also required that an updated Local Health Improvement Plan be created and presented to the LHIC, as well as a local diabetes initiative aligned with the Maryland Diabetes Action Plan. While this was challenging given the ongoing pandemic, it was also a good time to renew and refresh community health planning. Therefore, Health Department staff used the priorities identified through the 2018-2019 process, with new data and area-specific reviews, to refresh the LHIP.

In February 2022, a virtual community health planning meeting was held to engage a diverse group of community members who are not able to participate in daytime meetings to learn more about local health planning processes and opportunities for involvement. Many attendees are members of other community groups, such as the NAACP, churches, and healthcare businesses. Next steps after this meeting include a newsletter to keep members informed of leadership and action team meetings, events, and other activities, as well as planning and data updates. This community group was also asked to review the LHIP and provide feedback. The LHIC will continue to reach out to and expand this group, and search for other opportunities to involve them in local health planning.

This LHIP is significantly different than past reports, as the planning committee and LHIC chose to focus on SHIP priorities that are not being addressed as fully in Carroll County. SHIP data was reviewed to determine areas of focus, then reviewed in relation to other community plans:

- Community Health Needs Assessment, completed by The Partnership for a Healthier Carroll County in 2021
- Community Benefit Plan, completed by Carroll Hospital for 2022-2024

The LHIC's data review and prioritization process is described below.

II. Data Review and Prioritization

A summary of State Health Improvement Process data for Carroll County was presented to the LHIC/AHLT in October, 2018, focusing on areas where the county is not currently meeting state or national goals or is doing poorly compared to other counties in Maryland. Focus areas discussed were:

Access to/Awareness of Services Priorities

- Blood lead screening in children
- Adolescents who received wellness checkup
- Children who received dental care (CHNA)
- ED visits for dental care (CHNA)
- Annual flu vaccinations
- Affordable housing (CHNA – social determinant of health)

Behavioral Health Priorities

- Suicide rate (CHNA, CB-HIP)
- Drug-induced mortality rate (CHNA, CB-HIP)
- Poor mental health days (CHNA CB-HIP))
- Adults who smoke
- Adolescents who currently use tobacco

Chronic Disease Priorities

- Heart disease mortality rate (CHNA, CB-HIP)
- Cancer mortality rate (CHNA, CB-HIP)
- ED visits for diabetes (CHNA, CB-HIP)
- Adults who are not overweight/obese (CHNA, CB-HIP)
- Increased physical activity (CHNA, CB-HIP)

Older Adult Priorities

- Hospitalization for Alzheimer's or other dementias (CHNA)
- Fall-related death rate

Other Health Priorities

- Chlamydia

CHNA = Top 13 identified issue in 2021 Community Health Needs Assessment

CB-HIP = Issue Addressed in Community Benefit and Health Improvement Plan 2022-24

The LHIC/AHLT divided into small groups to discuss the data presented. Possible gaps in knowledge, access, and available services were noted. The group selected several priority issues where significant local service gaps may exist, and more information was needed:

Access to and Awareness of Services

- Lead screening guidelines, average lead levels in Carroll, resources available
- Impact of a public school program to take children to the dentist
- Ways to increase flu shots in younger adults (many initiatives for children and older adults)
- Affordable housing

Behavioral Health

- Suicide rate
- Drug-induced mortality rate
- Adolescents who use tobacco products, and electronic nicotine delivery systems

Chronic Disease

- Cancer – screening and prevention, focused on skin, breast, and colon cancer

These issues were discussed at 2019 Quarterly meetings, with several group members presenting on local programs in January; a panel on youth tobacco and e-cigarette use, trends, and regulations in April; and a panel on cancer screening recommendations and access in August. At the final LHIC meeting in October, 2019, data and information were reviewed and resources, gaps and barriers, and action steps and lead agencies were discussed to inform completion of the LHIP.

Notes:

Community Health issues related to chronic disease prevention and aging are coordinated by The Partnership's other Leadership Teams, Advancing Health and Wellness (AHAW) and Healthy Aging (HALT). These topics were not extensively discussed at these meetings because they are covered by these groups; however, the health issues will be reflected in the data, resources, and gaps section of this report. For some health priorities, additional data was included to more completely inform our community discussions.

Data refresh and review: In summer 2021, the data in the plan was updated. Health Department staff coordinated meetings in September, 2021 to review the data in each of the five priority groups (chlamydia was added to the Behavioral Health priority group), and resources, gaps/barriers, and action steps were discussed and updated for each data point by local subject matter experts and community providers. In March, 2022, additional data updates were made, and the final draft was reviewed by the LHIC/Access to Health Leadership Team and community health planning group. The LHIC/AHLT group will help to lead, coordinate, and support action steps to address these community needs moving forward.

III. Data, Resources, Gaps/Barriers, Action Steps and Leaders

Please note the following abbreviations:

AC - Access Carroll

AHAW - Advancing Health and Wellness Leadership Team (The Partnership)

AHLT - Access to Health Leadership Team (The Partnership)

BCCP - Breast and Cervical Cancer Program (Health Department)

BH - Behavioral Health

BOAD - Carroll County Bureau of Aging and Disabilities

BP - Blood pressure

BPWR - Bureau of Prevention, Wellness, and Recovery (Health Department)

CARE - Carroll Anti-Stigma Resiliency Campaign

CCC - Carroll Community College

CCHD - Carroll County Health Department

CPEST - Colorectal Cancer Program (Health Department)

CCPS - Carroll County Public Schools

CCRP - Carroll County Recreation and Parks

CS - Carroll County Citizens Services

CCYSB - Carroll County Youth Services Bureau

CH - Carroll Hospital

HALT - Healthy Aging Leadership Team (The Partnership)

HBP - High blood pressure

HSP - Human Services Programs, Inc.

LE - Law Enforcement partners

LHIC - Local Health Improvement Coalition

LMB - Local Management Board

LT - Leadership Team

MCHP - Maryland Children's Health Program

MCOs - Managed Care Organizations

MDH - Maryland Department of Health

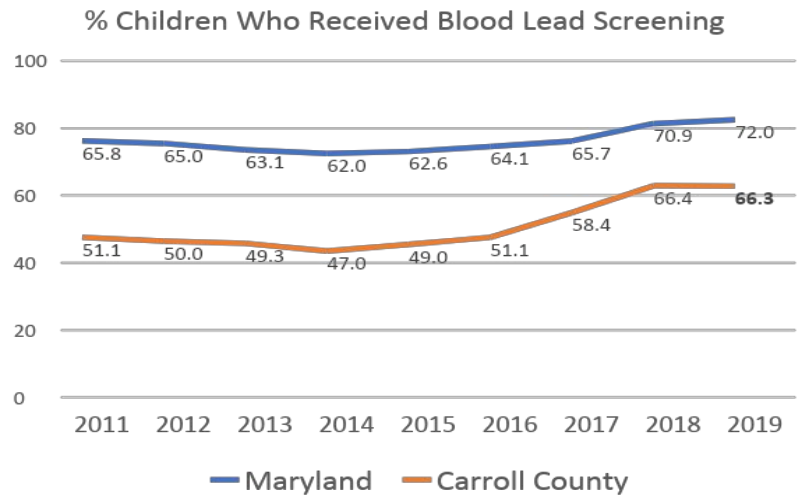
MSDE - Maryland State Department of Education

PHCC - The Partnership for a Healthier Carroll County

SHC - School Health Council

Access to / Awareness of Services Priorities

Children Who Receive Blood Lead Screening



This indicator reflects the percentage of children (aged 12-35 months) enrolled in Medicaid (90+ days) screened for lead in their blood.

Data Source: Maryland Medicaid Service Utilization, 2011-2019

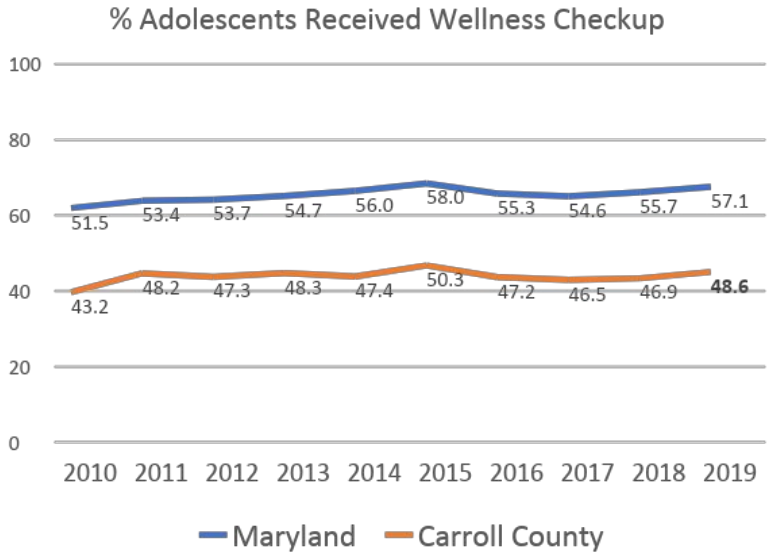
SHIP background: Each pediatric Medicaid enrollee should be screened for blood lead during their 12 and 24 months well-child visits. Children should also be screened if there is a risk and/or symptoms of lead poisoning.

Common sources of pediatric lead exposure include dust and paint chips from chipping or peeling lead paint, as well as lead-contaminated soil, toys, water, cosmetics, and folk medicines.

While blood lead screening levels are increasing with 2015 regulations requiring all children in Maryland to be tested for lead poisoning at 12 and 24 months, the LHIC/AHLT agreed that more could be done to raise awareness of screening guidelines among providers and parents. This will continue to be a topic of discussion.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Clinicians • Maryland Department of Health (MDH) staff • MDH videos and materials • WIC educational materials • Health Dept and MDE lead case management for children 10 mcg/dL and above	• MCOs could do more to promote • Some pediatricians are not a “one-stop shop” and don’t offer all required testing and vaccines • Not all pediatricians do the finger stick/capillary testing • Some parents are hesitant to get venipuncture blood draw • Some pediatricians are giving parents lab slips but not following up • Information should be provided to home buyers (when buying an older house) • Unclear how MSDE, childcare involved in lead screening promotion	• Review data on lead poisoning in county, state - CCHD • Look into shortage of fingerstick supplies - CCHD • Promotion, reminders for pediatricians and other providers who see children – suggest alternatives such as finger stick, testing blood drawn for other reasons, paper risk screening tool, pair with psychosocial screening - CCHD, CH, MCOs, MDH • More information for all parents on lead screening and lead poisoning – CCHD, CCPS (Judy Centers), community partners • Information through realtors, landlords - HSP to connect/provide information (member of Landlord Association) • Promotion of Healthy Homes for Health Kids program (helps low-income families pay for lead abatement) – CCHD, MDH • Education for parents through childcare facilities – HSP can distribute materials to ~80 in-home childcares; Extension, Childcare Choices, MSDE for facilities • Seek funding to do in-office capillary testing to increase compliance - TBD • Assess lead information state offers to providers – CCHD • Find a lab that does capillary testing (rather than venipuncture) – TBD • Lead Screening Questionnaire at events - CCHD • Add information into the School Health Council newsletter - CCHD, PHCC

Adolescents Who Received Wellness Checkup



The percentage of adolescents (ages 13-20 years old) enrolled in Medicaid (320+ days) who received at least one well-child visit during the past year.

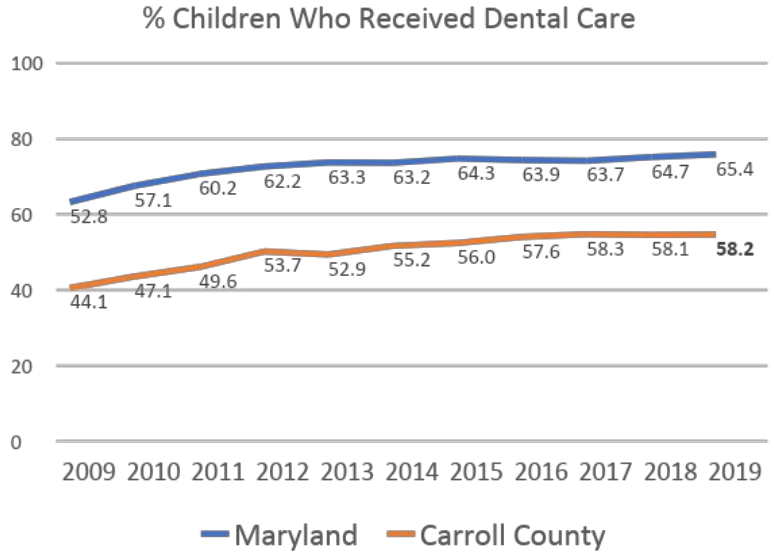
Data Source: Maryland Medicaid Service Utilization, 2010-2019

SHIP background: Adolescents are at higher risk for poor health outcomes associated with violence, injuries, substance use and abuse, sexually transmitted infections, unplanned pregnancies and homelessness. Well-child visits provide the opportunity for HCPs to engage in prevention of poor outcomes.

While this measure was not chosen as a priority by the LHIP, and does not correlate directly with a priority area in the CHNA or CBHIP, it does potentially reflect access to care issues, as well as an area for education and promotion. Some minor actions by team members could have a positive impact on adolescent outcomes.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Access Carroll for children who are unable to get insurance or are under-insured • International Back to School wellness day at Access Carroll	• Data only looks at Medicaid population • Transportation • Parents don't have time • Providers, insurance companies not emphasizing importance • MA doesn't make it easy to choose a provider • Access Carroll does not do much with children for now (so they are low on adolescent vaccines, etc), but they welcome more children for these visits and would stock more vaccines • HealthCare Access Maryland receiving much less funding to help people get and use health insurance	• Look for data on non-Medicaid population to see if this is a trend – CCHD • Educate on importance of adolescent wellness visits and how to use insurance - MCHP at CCHD, DSS • Connect with Boys and Girls Club, Together We Own It - CCHD, AC • Reach out to schools (i.e. athletics departments) • Send informational flyer with Shepherd's Staff to Shop with a Cop Back to School event - TBD • Ask service and faith-based organizations to advertise wellness checks - TBD • Add information into the School Health Council newsletter - CCHD, PHCC

Children Who Received Dental Care in Last Year



The percentage of children (aged 0-20 years) enrolled in Medicaid (320+ days) who received at least one dental visit during the past year.

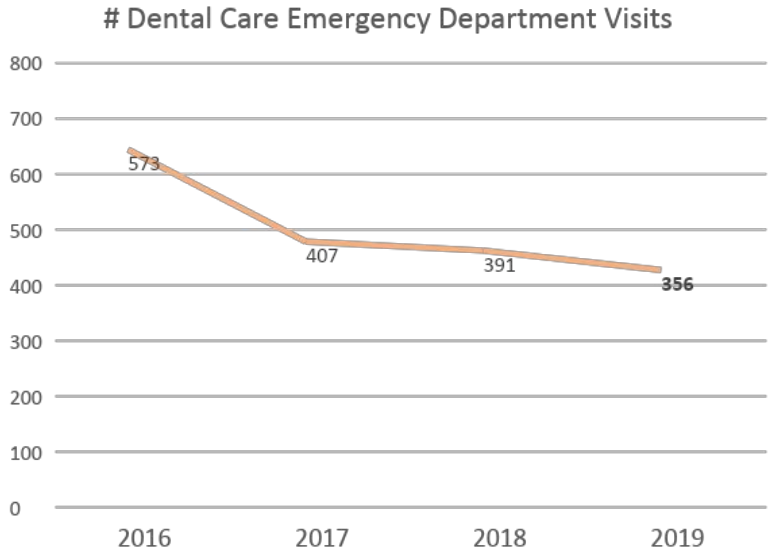
Data Source: Maryland Medicaid Service Utilization, 2009-2019

SHIP background: Poor oral health can lead to problems with nutrition, growth, school and workplace readiness, and speech.

The school system presented to the LHIC/AHLT on their new initiatives to provide dental care for children. The in-school dental program provides services on-site to students in three elementary schools. Three additional schools send children to a dentist; in the 2017-18 school year, 252 visits, 113 sealants, and 138 restorative treatments were provided. CCHD's pediatric dental clinic covers children up through age 18 and pregnant women, and has taken action to decrease appointment no-shows. Access Carroll's clinic also treats pediatric patients. The pandemic has made providing dental services very difficult, so progress has slowed in 2020-2022. Partner efforts could help improve the use of existing services.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• CCHD dental clinic (through age 18 and pregnant women) • Access Carroll seeing undocumented patients • Mission of Mercy • Healthy Smiles for families on Medical Assistance - CCHD • School-based dental programs	• Data only for Medical Assistance • Many families have insurance that doesn't cover dental • Would like more detailed School Mobile dental data • Transportation • Access during pandemic • IT issues - Health Dept can't access patient information to send reminders, due to statewide network incident	• Promote dental services at events for families - CCHD • Share information on dental services for students - CCPS • Provide information to childcare providers - CCHD, HSP • Add information into the School Health Council newsletter - CCHD, PHCC • Mobile Clinic Outreach - CCHD • Consider incentivizing dental care - MCOs

Dental Care Emergency Department Visits



Emergency department visits related to dental problems.

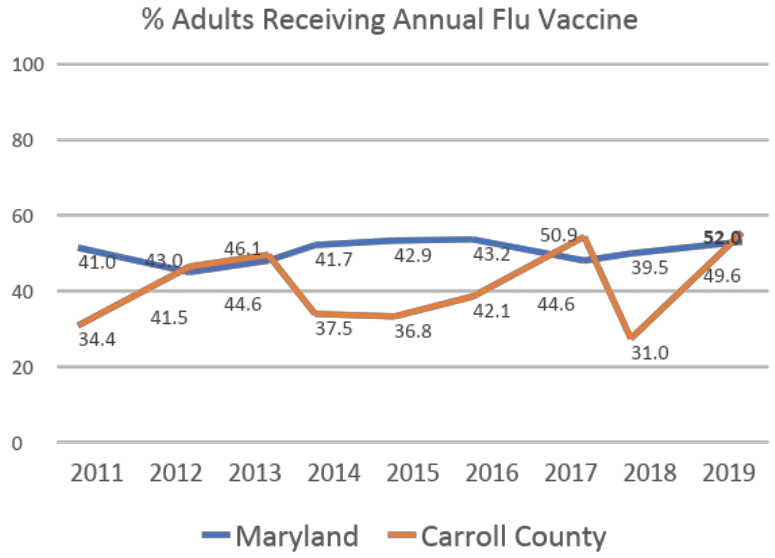
Data Source: Maryland Health Services Cost Review Commission (HSCRC), 2016-2019

SHIP background: The utilization of dental services in emergency departments has steadily risen over the last decade. Dental emergency department visits are growing as a percentage of all emergency department visits throughout the United States.

This was not chosen as a priority due to recent increase in services for adults with dental issues, at both Access Carroll and Mission of Mercy. However, we will continue to track our progress, and take action if there is a negative trend for this data point.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Health Department dental clinic • Access Carroll - Work with Carroll Hospital to stop giving out prescription pain meds for dental, do a block instead - Has relationship with UMD school of dentistry and residents - They have handled many ED diversions • Mission of Mercy • School-based dental programs	• None at this time, dental has really made some great changes over the years	• Share success stories - AC, CCHD, MOM (AC has data on ED diversions for dental) • Continue to promote resources

Adults Who Received Flu Vaccination



Percentage of adults who are vaccinated annually against seasonal influenza

Data Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

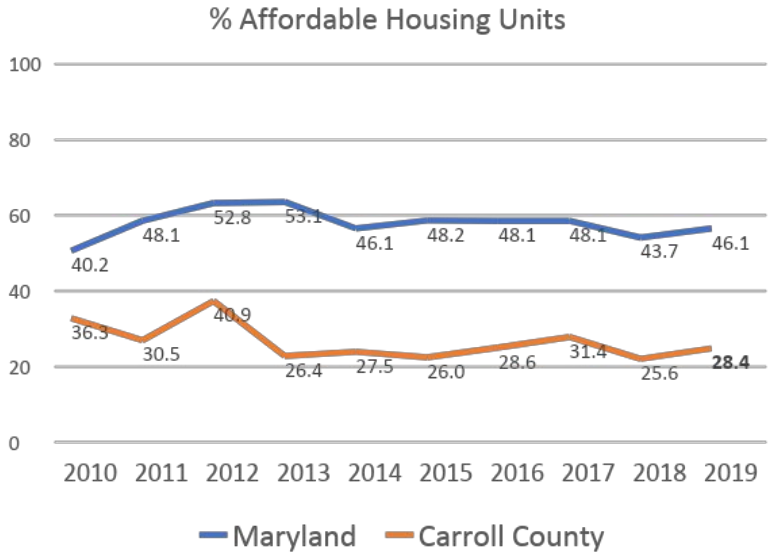
SHIP background: For many people, the seasonal flu is a mild illness, but for some it can lead to pneumonia, hospitalization, or death. Vaccination of persons in high-risk populations is especially important to reduce their risk of severe illness or death.

Mirroring state and national trends, in Carroll County younger children and older adults have much higher rates of flu vaccination than working-age adults (18-64). The county's Flu Vaccination Planning Committee, which includes many partners in the LHIC, meets annually and communicates regularly to plan community outreach and education efforts. In 2019, the flu planning group and the LHIC agreed to focus messaging on the working adult age group. The group discussed messages to encourage working adults to get the flu shot to protect others (children, elderly parents) and to avoid missing work, and new locations for outreach to target this age group, such as worksites and gyms.

Flu vaccination and illness were greatly impacted by the pandemic. The committee continued to share resource information and COVID and flu facts, and will collaborate to promote flu and COVID information again this fall.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Flu vaccination planning committee develops and distributes annually: - Flu flyer - Flu web page - Flu messaging - Flu shot clinics • CCHD, CCPS work with Maryland Partnership for Prevention to offer flu vaccine clinics in schools • Senior center vaccination clinics (drive through in 2021) - HALT, BOAD • Some worksites partner with pharmacies for onsite clinics • Flu vaccine accessible for under or uninsured, homeless - AC	• Pandemic drew focus away from flu vaccination for many people • Local data is inconsistent • Working age adults have low vaccination rates	• Bring flu vaccination to all shelters and facilities (AC already doing cold weather shelter and RSS; will work with HSP to do other shelters with vax from CCHD) - AC • Help senior housing complexes schedule flu vax clinics with pharmacies to improve resident access - CCHD • Review additional local data - CH • Consider visiting soup kitchens - CCHD • Continue flu vaccination committee action plans - CCHD and partners • Create and distribute targeted messaging for working adults - CCHD, PHCC, CH • Partner agencies offering flu clinics • Ensure pharmacy partners are consistently entering flu vaccines into ImmuNet to improve local data - CCHD • Ensure AC data entered into ImmuNet - CCHD • Coordinate with worksites, gyms – PHCC, CCHD

Affordable Housing



Percentage of housing units sold that are affordable on the median teacher salary

Data Source: Maryland Department of Planning (MDP), 2010-2019

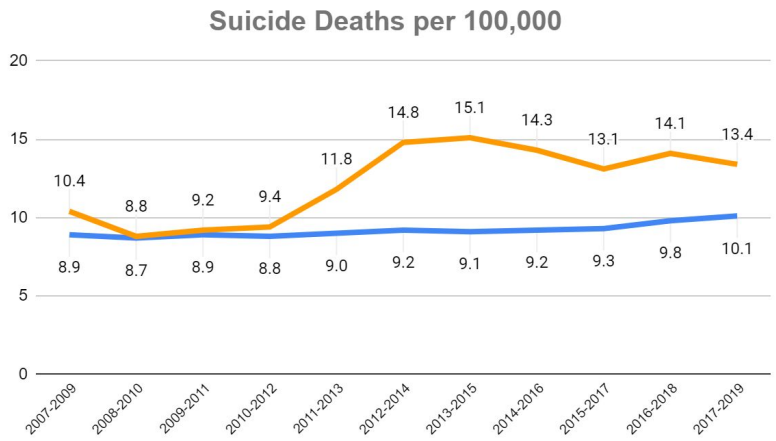
SHIP background: Affordable housing can improve health by providing greater stability and reducing stress. Having affordable housing can allow family resources to be used for other needs like healthy food and healthcare.

Affordable housing is challenging to define and address. The median income in Carroll County is high, and affordable housing options are not plentiful nor well-distributed throughout the county. However, the local community action agency, Human Services Programs, has recently adopted a "Housing First" model, and they, along with several other agencies with targeted housing programs for groups such as the chronically homeless and veterans, have successfully increased housing opportunities for many low-income individuals in the county.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• PATH program at CCHD • Housing subsidy for all or a portion of rent for low-income individuals- CCHD • Circle of Caring Homelessness Board - multiple agencies • Public Housing Authority at the Dept of Citizens Services - Increased Housing Stability Coordinators, increased vouchers for households with low income and/or disabilities (e.g. THRIVE Family Self-Sufficiency Program (FSS) helps families with Housing Choice Vouchers connect with resources for education, training, and employment; also Mainstream, HCV, FUP); "move on" strategy • Rental assistance, Rapid Re-Housing and Permanent Supportive Housing - HSP • Landlord Association meetings	• Elected officials don't believe there is a problem; need to increase awareness and involvement of other people beyond current affordable housing advocates • Median cost of housing has risen to over $400K per realty companies • Westminster City has a higher poverty level than rest of county • Current zoning/building laws do not allow for new development • Housing inventory low • Still not enough vouchers to meet all need • Need more coordinated case management • Financial management education would also help • Still a very complex issue. Need specialists who help to figure out where to start. • COVID funding helped people get housed; moratorium on evictions	• Coordinate LHIC/AHLT efforts with Circle of Caring, Habitat for Humanity; continue to stay informed • Increase social determinants of health screening to connect health and housing - multiple agencies • Increase number of vouchers - CCG PHA • Case mgt to help high-risk maintain housing - CCG PHA • Continue to look for funding opportunities • Help advocate for additional resources and support

Behavioral Health Priorities

Suicide

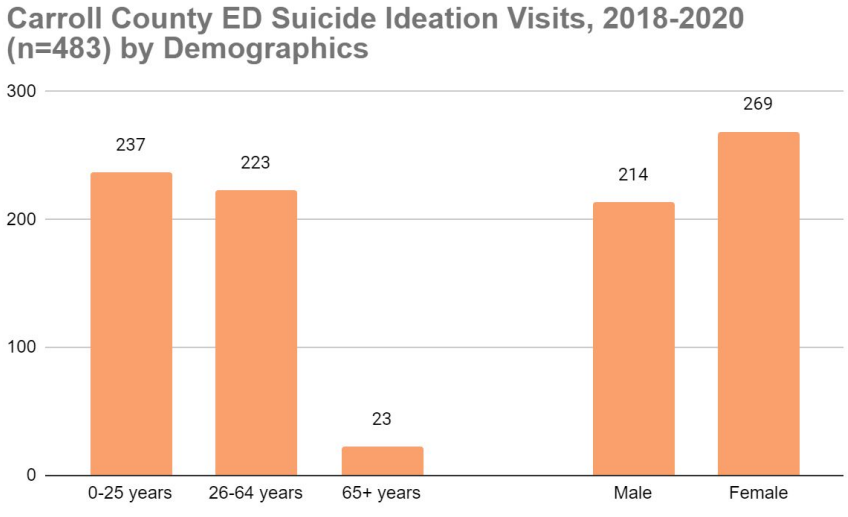


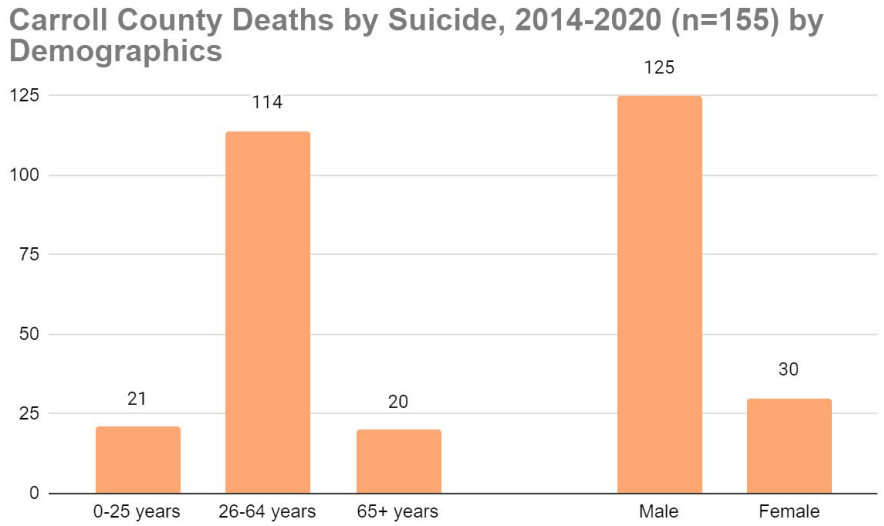
Age-adjusted suicide rate per 100,000 population

Data Sources: Maryland Vital Statistics Administration (VSA) Annual Reports, 2009-2019; Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE), 2018-2020

SHIP background: Suicide is a serious public health problem that can have lasting effects on individuals, families and communities. Mental disorders and/or substance abuse have been found in the great majority of people who have died by suicide.

Carroll County's suicide rate is trending downward after peaking in 2013-2015, but we are higher than the Maryland value.

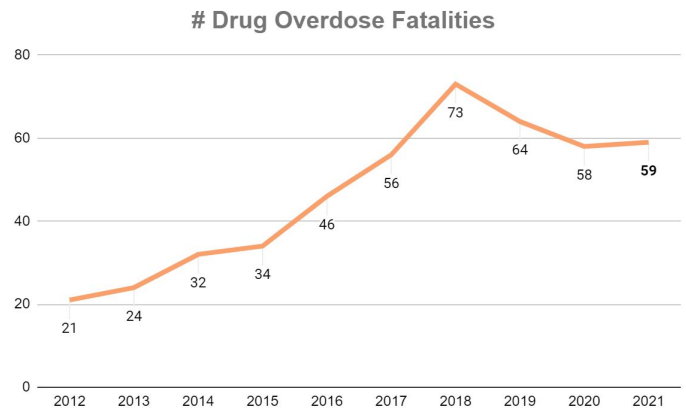




Suicide, cont.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Behavioral health crisis services, hotline • Sources of Strength in middle and high schools - CCPS • Handle with Care – LE, CCPS • CARE Anti-stigma campaign – PHCC, CCHD, CH • LCPC program at McDaniel • Mobile Crisis • Critical Incident Stress Management Team • Mental Health First Aid – CCHD, CCC • Carroll Hospice Bereavement groups • Support groups for families and adult survivors of suicide • Community Trainings (e.g. Ruby Payne's emotional poverty, Risky Business, etc.) • Suicide Prevention Coalition • Suicide Prevention Team at CCYSB (LMB grant funded program to provide outreach, intervention and expand treatment for youth at risk for suicide; also provide presentations at all CC high schools, and some elementary and middle schools; also provided PCP/dentists/orthodontists/urgent care providers with info packets for patients and waiting rooms • NAMI Hotline • Support group once a month (called Hope) • St. Paul's United Church of Christ (at Bond & Green Streets) is a WISE Congregation (Welcoming, Inclusive, Supportive and Engaged) – safe and supportive landing place for people seeking church involvement, with mental illness, substance abuse, and brain disorders	• Programs targeted toward high schools • LCPC reimbursement issue through Medicare • All school staff not yet trained in Youth Mental Health First Aid • Pediatricians and PCPs need more training to help patients • Suicide education • Increase Behavioral Health services • Not all grade level teachers have received Trauma-Informed Care Training • Need more continuing education in Behavioral Health	• Suicide awareness and prevention trainings and initiatives (i.e. response card) – Suicide Prevention Coalition (CCHD/BPWR) • Sources of Strength expansion plans – CCPS, CCHD, detention center, others • C.A.R.E. campaign to reduce stigma – PHCC • Survey general practitioners and pediatricians about their use of universal screening for depression and suicidal ideation – CCHD/BPWR • Ensure all elementary, middle, and high school teachers are trained in trauma-informed care – CCPS, CCHD/BPWR • GBRICS initiative (Greater Baltimore Regional Integrated Crisis System) will help to expand mobile crisis to 24 hour call center • 988 National Crisis LIne going live around July, 2022 - group can help promote, educate providers and public • Joint Commission has new focus on suicide prevention with required trainings for all office staff and providers, as well as office risk assessment; LHIC/AHLT to look for training resources.

Drug-Induced Deaths



Overdose fatalities: Includes all deaths for which illicit or prescription drugs are the underlying cause of death.

Data Source: Overdose Fatality Crisp Reporting Services Dashboard (BHA and VSA data), preliminary data, 2012-2021

SHIP background: In 2007, drug-induced deaths were more common than alcohol-induced or firearm-related deaths in the United States. Between 2012-2014, there were 2,793 drug-induced deaths in Maryland.

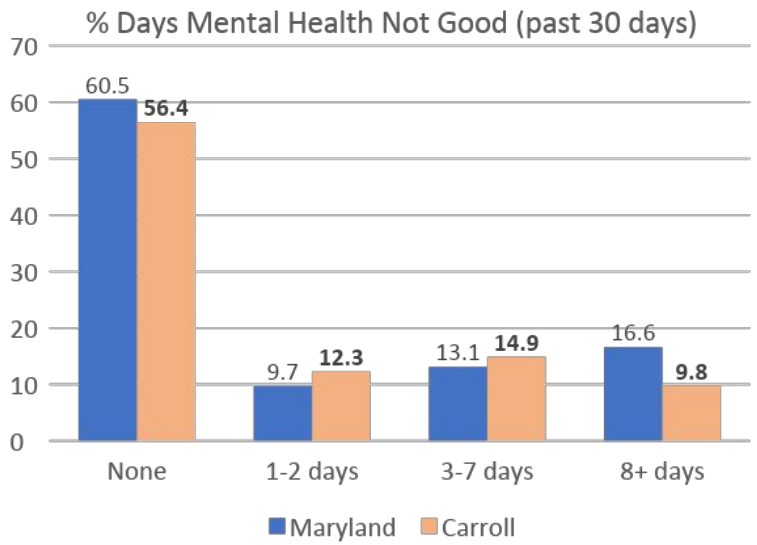
According to the Maryland Opioid Dashboard from the Opioid Operational Command Center, Carroll County had a 38.7% increase in opioid-related fatal overdoses from 2020 to 2021, the highest in any Maryland County. https://experience.arcgis.com/experience/c546d22ec4a946cbb700a282f53c6eb7/

Drug overdoses continue to be a great issue of concern in Carroll County.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Peer Support at CCHD and CH • Increased treatment facilities • Opioid Prevention Coalition • Opioid Senior Policy group - many agencies and elected officials • Mobile Crisis Team • CARE Anti-stigma campaign • Substance Use Loss group – Carroll Hospice • Narcan training • EMS Leave Behind (Narcan) • Fentanyl test strips • Mountain Manor • Addiction Healing Center (have peers and long term recovery and transitional housing for men and women) • Harm Reduction Program – CCHD • St. Paul's United Church of Christ (at Bond & Green Streets) is a WISE Congregation (Welcoming, Inclusive, Supportive and Engaged) • Boys and Girls Club uses Not in Carroll funding to run the SMART Moves program (evidence-based) which teaches youth how to resist alcohol, tobacco and other drugs, and to overcome obstacles that impede their development in leading successful lives and achieving their goals.	• More business owners need to be trained in Mental Health First Aid, educated about hiring people in recovery • Not enough postvention services, such as targeted outreach to those who have had an overdose, offering treatment, family outreach, housing, and workforce development • Challenge with access to care in rural areas • Transportation • LGBT focused support with knowledgeable providers needed • Immediate access to treatment	• Mobile Care Collective RV to increase access in underserved areas – CCHD and community partners • Work with Chamber of Commerce to facilitate efforts with local businesses – CCHD/BPWR and Chamber • Writing grant to fund postvention interventions – CCHD • Westminster Police Department working on overdose rapid response pilot • GBRICS initiative (Greater Baltimore Regional Integrated Crisis System) will help to expand mobile crisis to 24 hour call center • Local Overdose Fatality Review Team (LOFRT) meetings discuss cases and what could have been done to prevent case - CCHD

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Peer Support at CCHD and CH, WRM • Increased treatment facilities • Opioid Prevention Coalition • Substance Use Prevention in schools, Heroin Still Kills - CCHD • Opioid Senior Policy group - many agencies and elected officials • Mobile Crisis Team • CARE Anti-stigma campaign • Substance Use Loss group – Carroll Hospice • Narcan training • EMS Narcan Leave Behind • Fentanyl test strips • Mountain Manor • Sober Truth home supporting MAT (Medication-Assisted Treatment) • Addiction Healing Center (have peers and long term recovery and transitional housing for men and women) • Harm Reduction Program – CCHD, WRM • Behavioral Health hotline supported by LifeBridge, at AC • St. Paul's United Church of Christ (at Bond & Green Streets) is a WISE Congregation (Welcoming, Inclusive, Supportive and Engaged) • Boys and Girls Club uses Not in Carroll funding to run the SMART Moves program (evidence-based) which teaches youth how to resist alcohol, tobacco and other drugs, and to overcome obstacles that impede their development in leading successful lives and achieving their goals. • Sober homes meeting to coordinate efforts, share strategies.	• More business owners need to be trained in Mental Health First Aid, educated about hiring people in recovery • Not enough postvention services, such as targeted outreach to those who have had an overdose, offering treatment, family outreach, housing, and workforce development • Challenge with access to care in rural areas • Transportation • LGBT focused support with knowledgeable providers needed • Immediate access to treatment • Not enough family support services, esp. for families with loved ones who are not in treatment	• Mobile Care Collective RV to increase access in underserved areas – CCHD and community partners • Work with Chamber of Commerce to facilitate efforts with local businesses – CCHD/BPWR and Chamber • Writing grant to fund postvention interventions – CCHD • Westminster Police Department working on overdose rapid response pilot • GBRICS initiative (Greater Baltimore Regional Integrated Crisis System) will help to expand mobile crisis to 24 hour call center • Local Overdose Fatality Review Team (LOFRT) meetings discuss cases and what could have been done to prevent case - CCHD • More training opportunities for peers - CCHD, CH, WRM • Expand harm reduction efforts to more recovery homes, • Support new Quick Response Team with Westminster PD for hours mobile crisis is not available (11 pm - 9 am)- LE, MH provider, peer coordinate with harm reduction - CCHD, LE • Work with Fire/EMS to provide more services to high utilizers

Poor Mental Health Days



Survey respondents were asked, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

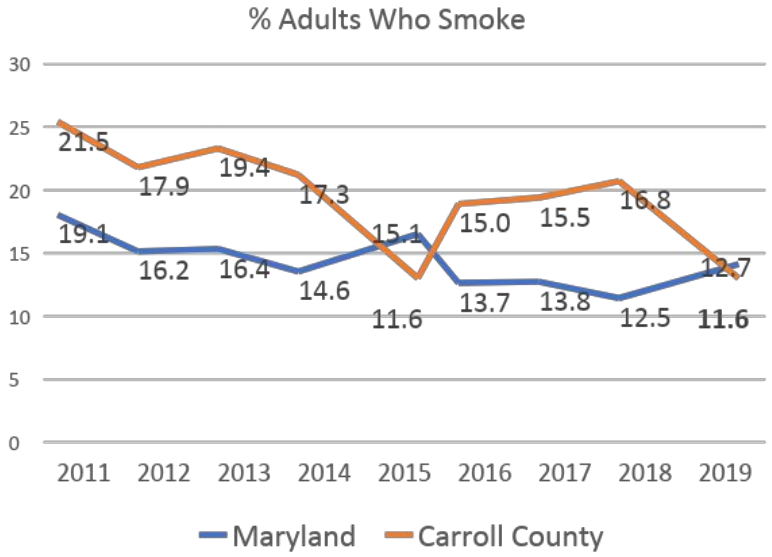
Data Sources: MD Behavioral Risk Factor Surveillance System (BRFSS), 2019

Though this data point is not from SHIP,, we chose to include it to support the 2021 Community Health Needs Assessment prioritization of mental health. This data only extends through 2019, and is likely to show an increasing trend due to pandemic stress and isolation.

The Behavioral Health Advisory Council brings together community partners working to increase access to local behavioral health services.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Resources given out for self-help – CCHD/BPWR • Behavioral Health directory now interactive online database- PHCC • Service Coordination - CCHD (BPWR) • CARE Anti-Stigma Campaign - PHCC • COVID-19 support group • Mobile Crisis • St. Paul's United Church of Christ is a WISE Congregation (Welcoming, Inclusive, Supportive and Engaged) – safe and supportive landing place for people seeking church involvement, with mental illness, substance abuse, and brain disorders	• Not enough awareness of resources including Mobile Crisis • Not as many resources related to COVID-19 burnout • Gap in providers knowing there is the ability to do uninsured requests when someone comes in without insurance; they can get paid in the interim before patient's Maryland Medicaid kicks in • Lack of psychiatrists; long waiting lists • Lack of walk-in services/same-day access • Gap between hospital level of care and outpatient; not much in between	• GBRICS initiative (Greater Baltimore Regional Integrated Crisis System) will help to expand mobile crisis to 24 hour call center, and same day access • Seek opportunity for funding to link BH providers with reproductive services at CCHD -Due to higher rates of pregnancy and STI's -Mandatory screening for substance abuse and mental health -Would like to have a warmer hand-off • Expand access to telehealth - CCHD, partners • Expand BH capacity, midlevel providers - CCHD, partners • Work on same-day access to MH services – CCHD • Increase awareness of BH services – CCHD, PHCC, others • CARE Campaign resources, mental health education for providers - PHCC

Adults Who Smoke



Percentage of adults 18+ years who currently smoke

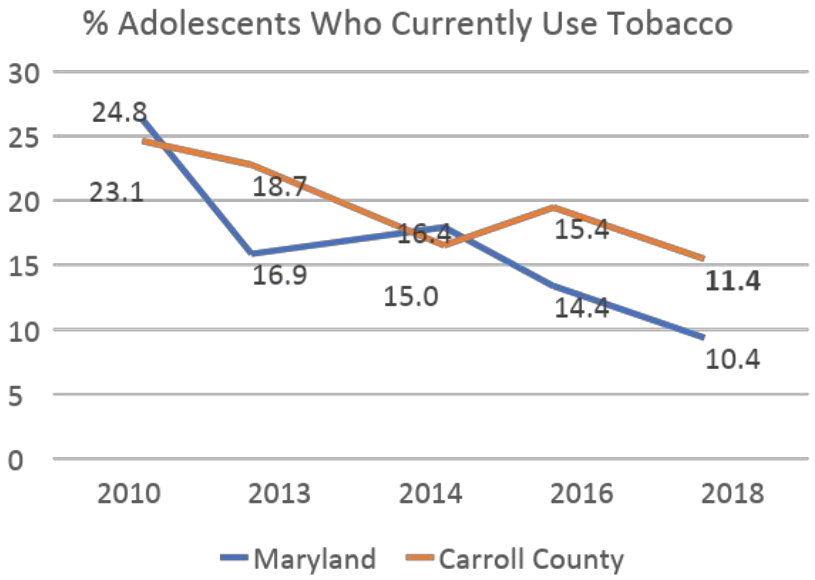
Data Source: Maryland Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

SHIP background: 7,500 adults in MD die each year due to tobacco-related causes, and 150,000 more suffer from tobacco-related diseases such as COPD, emphysema or cancers. Non-smokers, especially young children, are also affected through exposure to toxins found in secondhand smoke.

Tobacco use among adolescents and adults is decreasing, but we need to continue our efforts and incorporate electronic smoking device use data.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Free counseling by phone, or in-person counseling by appointment - CCHD • Free nicotine replacement products regardless of insurance – CCHD • Theracoustic beds for tobacco use reduction – AC • Auricular acupuncture (sliding scale fee) - AC • Increased virtual services during pandemic - CCHD	• Access to care in rural areas • Transportation • Lack of referrals from other agencies • Limited nicotine replacement products • Cost of Chantix has gone up significantly ($600 per month without insurance; used to be $150), so CCHD unable to give out as much as they used to; but many individuals feel this is the only treatment that works for them • Expanding the discussion of smoking to include vaping	• Outreach to agencies and providers to increase referrals to services- CCHD • Encourage businesses to have “no smoking on premises.” Incentives for employees to quit smoking. - CCHD

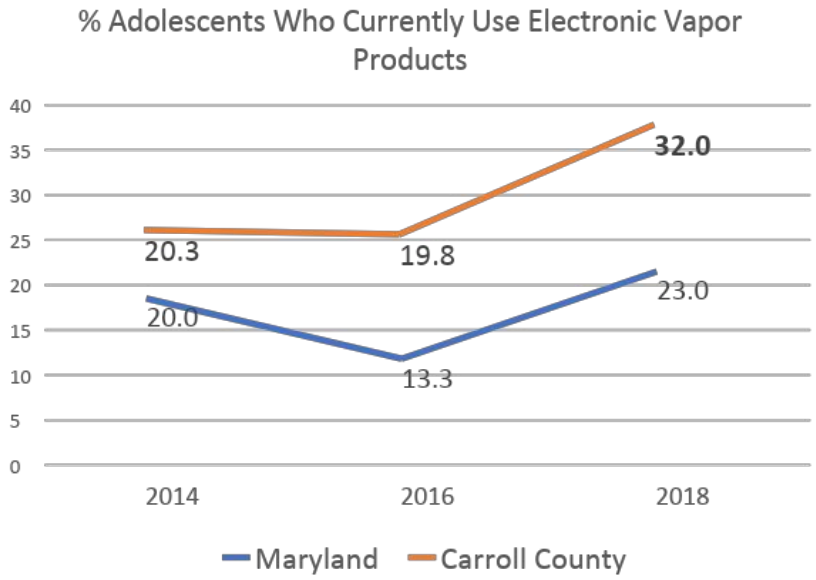
Adolescent Tobacco & ENDS (Electronic Nicotine Delivery System) Use



Percentage of adolescents (public high school students) who used any tobacco product in the last 30 days; Percentage of adolescents (public high school students) who used any electronic vapor products in past 30 days.

Data Source: MD Youth Risk Behavior Survey, High School (YRBS), 2014-2018

SHIP background: Tobacco use is a highly addictive behavior that can lead to costly illnesses and death to users and those exposed to secondhand smoke. Most e-cigarettes contain nicotine, which is highly addictive and can harm adolescent brain development.

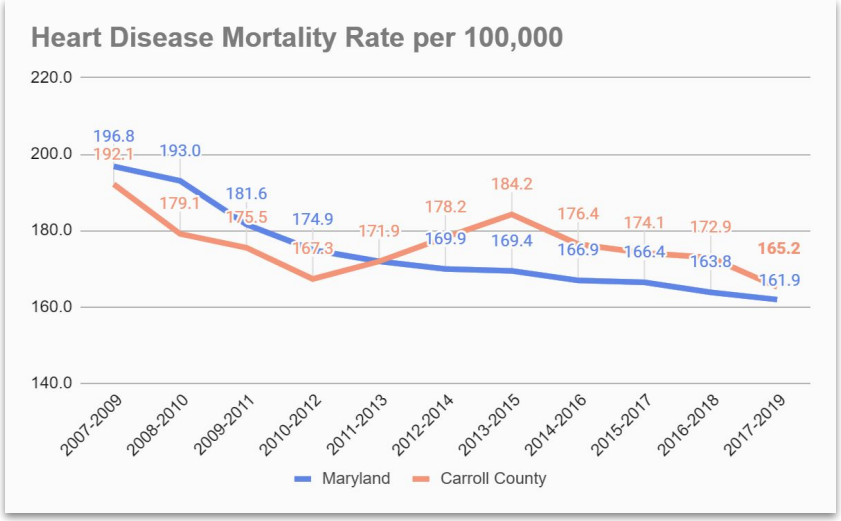


Adolescent Tobacco & Electronic Vapor Product Use

Current Resources	Gaps/Barriers	Action Steps and Leaders
• School health curriculum programming on cigarettes, e-cigs, nicotine at all ages • Programs for parents • TEG program in schools	• Cannot provide nicotine replacement for youth under age 18 • No proven products for vaping cessation • No proven interventions for vaping cessation • Conflicting information about harms/benefits of vaping • Many clients are in the BH system; if the campus they are going to for BH services is non-smoking, then it deters them to get the services that they need. Ensure that in-patient settings offer nicotine replacement.	• Promote policy changes at school system level for mandatory confiscation of vaping products without return – CCPS • Meet the coaches night – making vaping/smoking cessation a mandatory part of the curriculum – CCPS • Provide referral cards for teens with quitting resources – CCHD • Parent education on dangers of vaping – CCPS, CCHD • Provide funding for middle schools to develop an anti-vaping campaign in the schools – CCHD • Create peer to peer program; have college students working with HS students; or athlete to athlete peer - CCHD, CCPS

Chronic Disease Priorities

Heart Disease Mortality Rate



Age-adjusted mortality rate from heart disease per 100,000 population

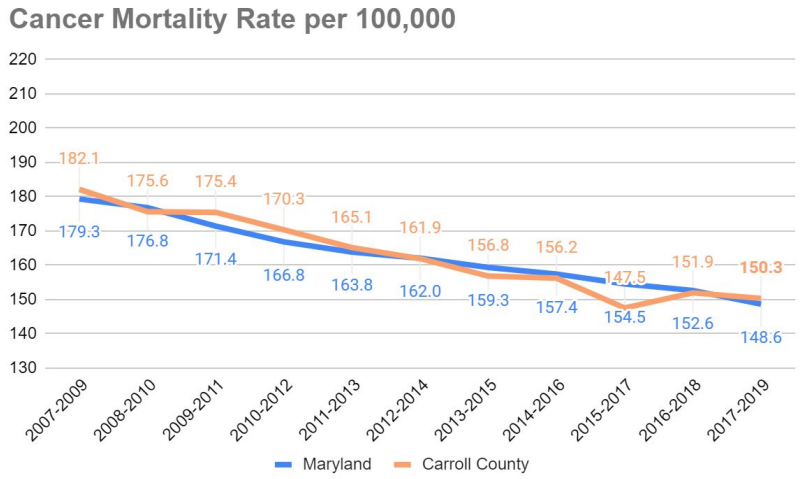
Data Source: Maryland Vital Statistics Administration (VSA) Annual Reports, 2009-2019

SHIP background: Heart disease is the leading cause of death in Maryland and accounts for 25% of all deaths.

Though the heart disease mortality rate in Carroll County is decreasing, it is still higher than Maryland's rate. Many local efforts center around raising awareness and increasing use of existing healthy lifestyle resources, but some heart health promotion is also needed.

Current Resources	Gaps/Barriers	Action Steps and Leaders
Nutrition: • PHCC Advancing Health and Wellness LTs' Prescription for nutrition (Farm to Plate, Carroll's Cooking Community Garden & NoBody's Perfect) • Services at hospital (outpatient and diabetes education) • Healthy Bites program at CH • Farmers' Markets Physical activity: • PHCC Advancing Health and Wellness LTs' (Walk Carroll, Trail Passport, Gym Passport) • Parks and trails • Recreation and Parks programs • Walking programs (Walk Carroll – PHCC) • Senior Center programs for 60+ • Community programs like TryVent to introduce activity options • Living Healthy, Living Well classes • Medications (connecting people to a healthcare provider to manage their risks for heart disease/diabetes) • Cardiac Rehab • Smoking cessation services at the Health Department	Nutrition: • Physician-ordered services limited • Insurance coverage for nutrition services limited • Access to community-based, non-physician, non-insurance related service limited Physical Activity: • Connecting trails to increase access • Education and awareness of resources, importance of exercise • Cost (sidewalks are expensive) • Transportation • Cardiac Rehab is underutilized • Need to raise awareness of HBP and importance of BP control	• Improve provider referral process - CCHD • Provide information for doctors to share with patients about heart healthy activities and local resources – AHAW • Medication Management program – CH • Find support for self-monitored blood pressure programming - CCHD • Develop programs and messaging campaigns to increase patient accountability for their health-related behaviors – AHAW • Recreation & Parks planning committee bike/pedestrian master plan – CCRP

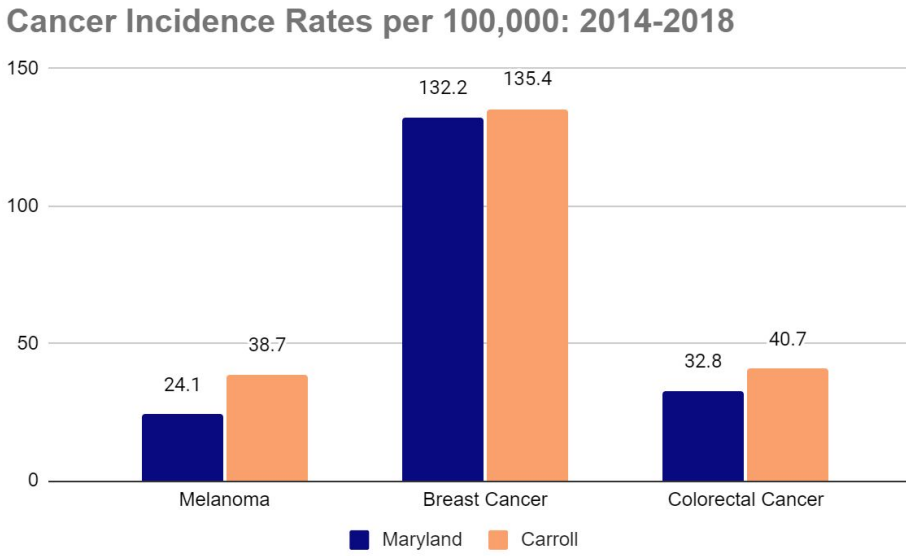
Cancer Mortality

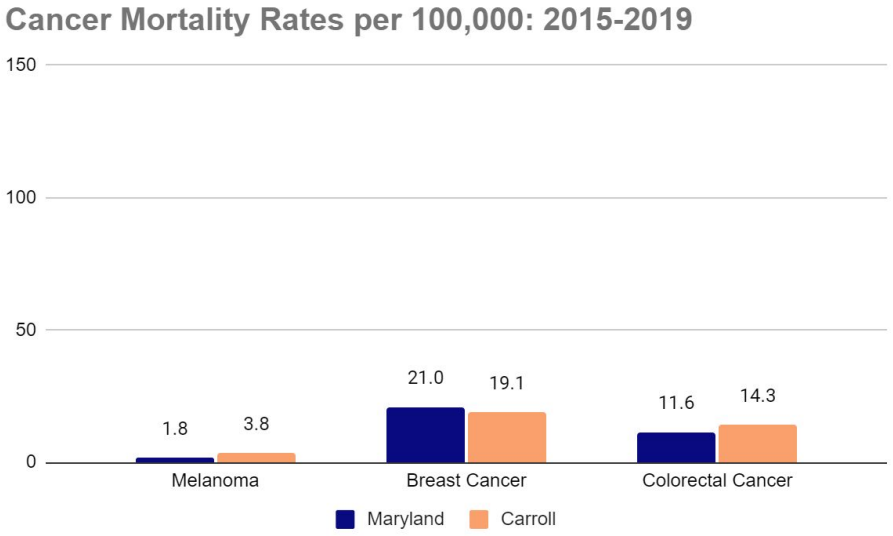


Age-adjusted mortality rate from cancer per 100,000 population
Data Sources: Maryland Vital Statistics Administration (VSA) Annual Reports, 2009-2019, CDC State Cancer Profiles

SHIP background: Maryland's age adjusted cancer mortality rate is higher than the US mortality rate. Cancer impacts people across all population groups; however, significant racial disparities exist.

Carroll County's cancer mortality rate is relatively low compared to other counties. Therefore, the LHIC's original conversation about cancer focused on increasing awareness of screening recommendations, and resources to help people in need to access screenings and treatment. Our August, 2019 meeting focused on resources for breast and cervical cancer, lung cancer, and colorectal cancer. These cancers were chosen due to relatively high rates in Carroll, but also the availability of resources.





Cancer cont.

Measure (Source: 2018 BRFSS)	Carroll	Maryland
Had Mammogram in past 2 years (women age 40+)	82.7%	75.1%
Had Pap Test in past 3 years (women age 18+)	64.5%	70.3%
Ever had sigmoidoscopy or colonoscopy (age 50+)	69.3%	75.7%

Lowering Cancer Mortality Rates and Increasing Screening

Current Resources

- Skin cancer prevention programming (Safer in Shade, Fun in the Sun, Melanoma education) - PHCC, CCHD
- William E Kahlert Regional Cancer Center (screening, education, treatment, Survivorship Programs, nutritional and counseling services for oncology patients, palliative care options, complementary health services)
- Free annual breast/skin cancer screenings – CH
- Breast and Cervical Cancer Program – CCHD
- CPEST program (colorectal cancer screening) – CCHD
- Maryland Cancer Fund – treatment program for those that are low income/underinsured – CCHD
- HPV vaccination through schools

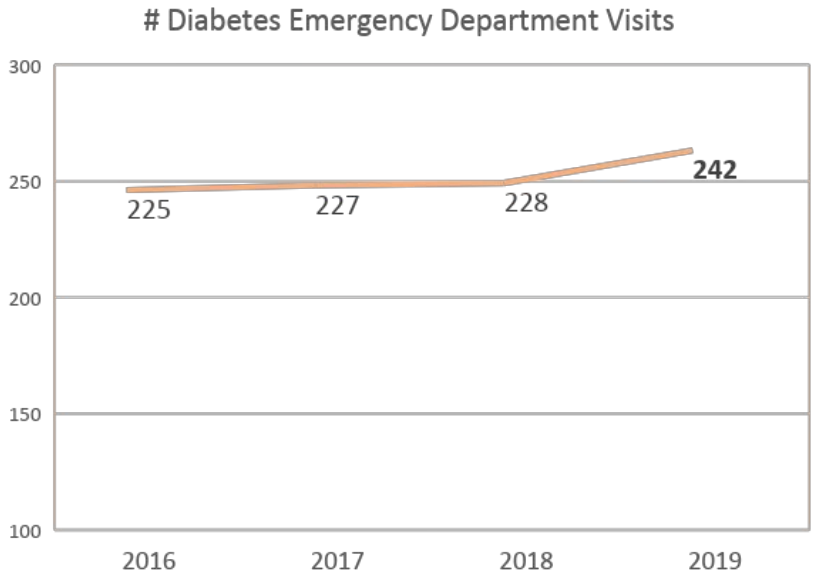
Gaps/Barriers

- Efforts needed to target high risk women who are <40 since they are not typically able to be covered for mammograms (in health dept programs with income eligibility)
- Cervical – Increase awareness of importance of early HPV vaccination in parents of teens
- Cost/lack of insurance is huge concern. Could be helpful to determine in what cases the colonoscopy is considered “preventative” and covered by insurance at no or low cost.

Action Steps and Leaders

- Increase public awareness of BCCP program for women >40 – CCHD, CH
- Increase provider awareness of BCCP program – CCHD
- Increase public awareness of colorectal cancer prevention and new screening guidelines (age 45)- CCHD
- Increase provider awareness of colorectal cancer screening program - CCHD
- Increase public awareness of lung cancer screening - CCHD, CH
- Offer more skin cancer screenings – CH
- Increase awareness of all cancer recommendations and resources - AHAW, HALT, LHIC/Access

Diabetes

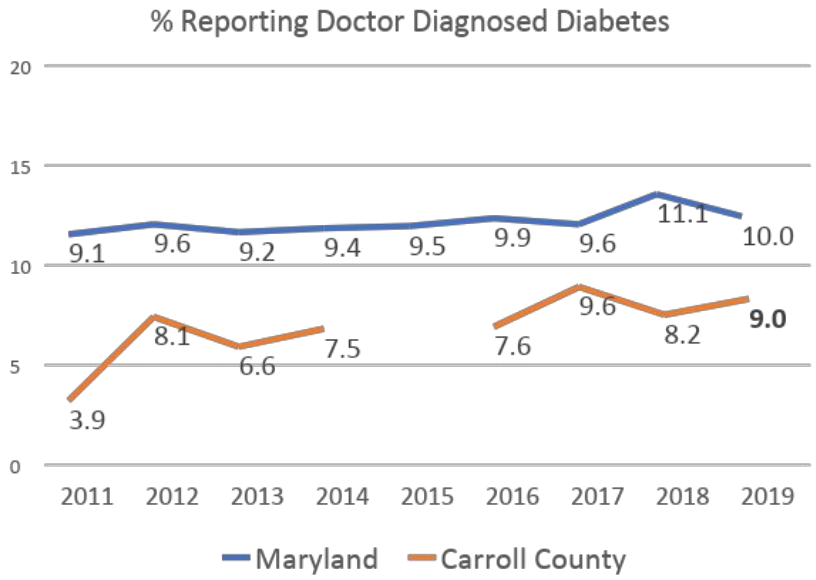


Emergency department visits for primary diagnosis of diabetes

Data Sources: Health Service Cost Review Commission (HSCRC), 2016-2019 & Maryland Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019

SHIP background: Diabetes can lead to blindness, heart and blood vessel disease, stroke, kidney failure, amputations, pregnancy complications, etc.

Diabetes was chosen as the focus of Maryland's Chronic Disease Efforts, leading to the state's Diabetes Action Plan, and funding for prediabetes and diabetes efforts. Resources to prevent and manage diabetes will also help reduce the negative impact of other chronic diseases.



Diabetes, cont.

Lowering Diabetes Diagnosis and Emergency Department Visits

Current Resources

- Diabetes Self-Management Education and diabetes and prediabetes education - CH
- Diabetes Self-Management Program and Chronic Disease Self-Management Program - BOAD
- National Diabetes Prevention Program (NDPP) - CCHD
- Nutrition programming - CH
- Walk Carroll walking clubs - PHCC
- Wellness events - PHCC
- QI project in provider offices, CH and CCHD, supported by MDH
- No-cost diabetes and prediabetes screenings by CH
- Social media campaigns to raise awareness of prediabetes and healthy lifestyle resources - CCHD, PHCC - AHAW/NAT

Gaps/Barriers

- No widely-available, current resources for worksite wellness (AHAW LT created a Worksite Wellness Toolkit available on PHCC website)
- Need to develop improved referral process between providers and all community wellness programs
- Cost of some programs – what is ordered by physician, covered by insurance
- Low public awareness of prediabetes and diabetes prevention resources
- Diabetes Prevention Program (NDPP) is very long program
- Low provider awareness of wellness resources
- Patient lack of knowledge and understanding of disease process
- Need increased outreach to rural, minority, faith-based, other community partners

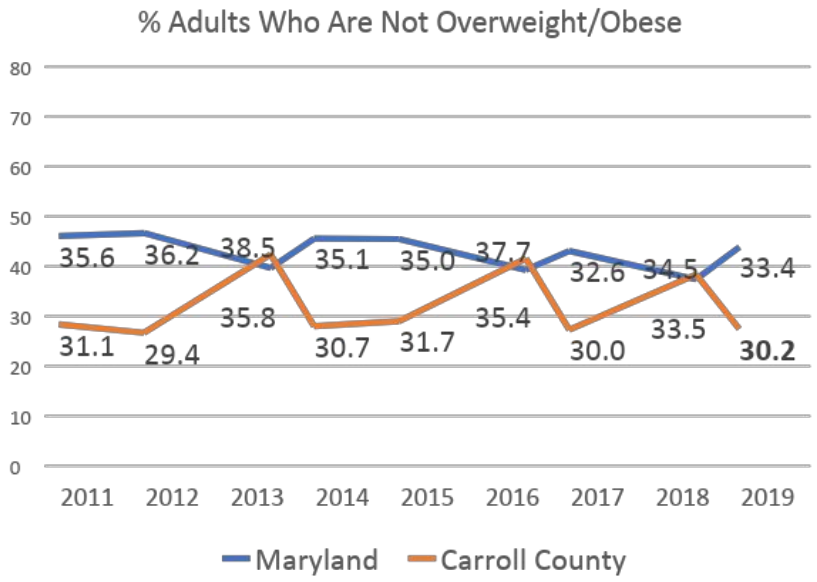
Action Steps and Leaders

- Initiate policy changes at the leadership level – Population Health Governance Group
- Use Carroll County Public Library's Exploration Commons for community wellness activities - PHCC
- Increase provider referrals to community wellness programs – CH, CCHD
- Take NDPP to businesses and other community groups – CCHD
- Expand number of courses, instructors for NDPP - CCHD

State priority spotlight
Diabetes Initiative:

- **Goal -to reduce the negative health outcomes related to diabetes in Carroll County**
- **Objective- to raise awareness of prediabetes and use of healthy living resources to prevent diabetes**
- **Strategies - develop a multimedia marketing campaign to promote the prediabetes risk test, diabetes prevention and healthy lifestyle resources; to offer healthy incentives for program participation**
- **Measures- media analytics, registration and participation in healthy lifestyle/diabetes prevention and management programs**
- **Leaders – CCHD,PHCC, CH, BOAD, Extension**
- **This effort will support other chronic health initiatives including heart disease, obesity, and physical activity.**

Obesity & Physical Activity

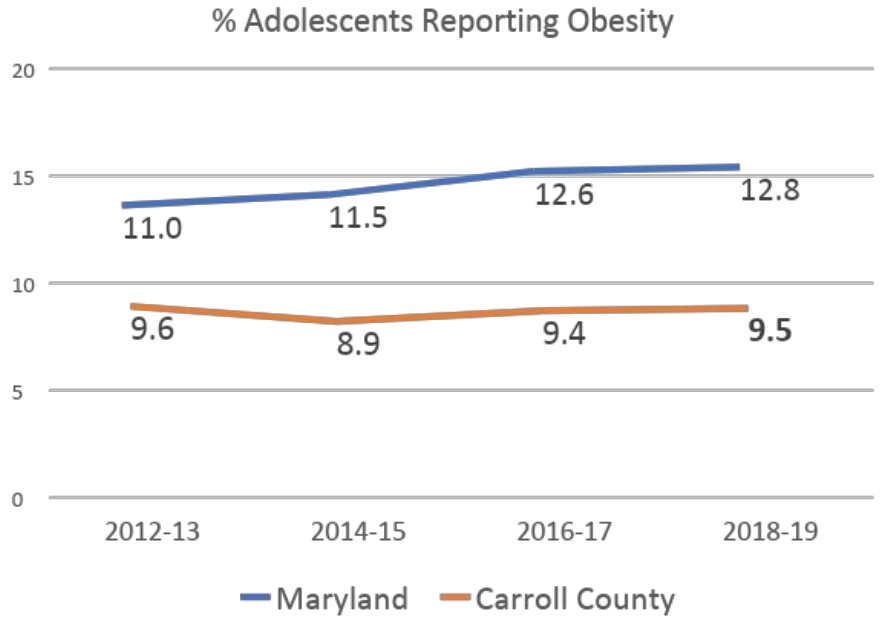


Overweight adults are defined as individuals 18 years and older with a BMI ≥25, while adult obesity is defined as adults with a BMI ≥30.

Adolescents with obesity defined as % of high school students who had obesity (≥95th percentile BMI, based on sex and age-specific reference data from the 2000 CDC growth charts).

Data Sources: Maryland Behavioral Risk Factor Surveillance System (BRFSS), 2011-2019 & Youth Risk Behavior Survey (YRBS), High School, 2012-2018

SHIP background: Obesity linked to high blood pressure, high cholesterol and diabetes. Carroll County has more adults who are overweight or obese than the Maryland average, but fewer adolescents reporting obesity. The pandemic made it challenging for many to maintain or achieve a healthy weight. New effort is needed to provide information and resources to help county residents lose and maintain a healthy weight.

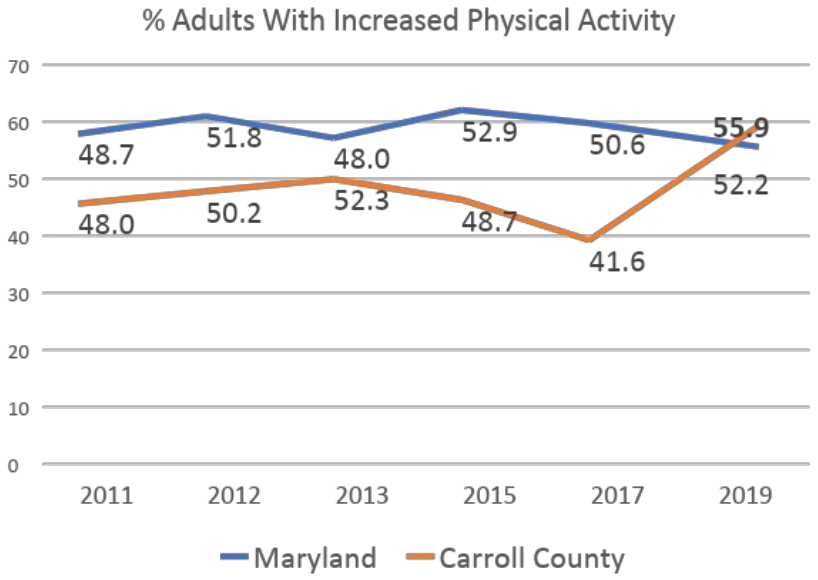


Obesity & Physical Activity, cont.

Physical activity defined as 150 minutes of moderate physical activity (or at least 75 minutes of vigorous physical activity) per week.

Physical activity is important to prevent heart disease and stroke, obesity, and many other chronic health conditions.

Historically, the percentage of adults with increased physical activity has been lower than the state average, but trends are positive. We can continue to provide more opportunities and incentives to reinforce and increase physical activity in all ages.

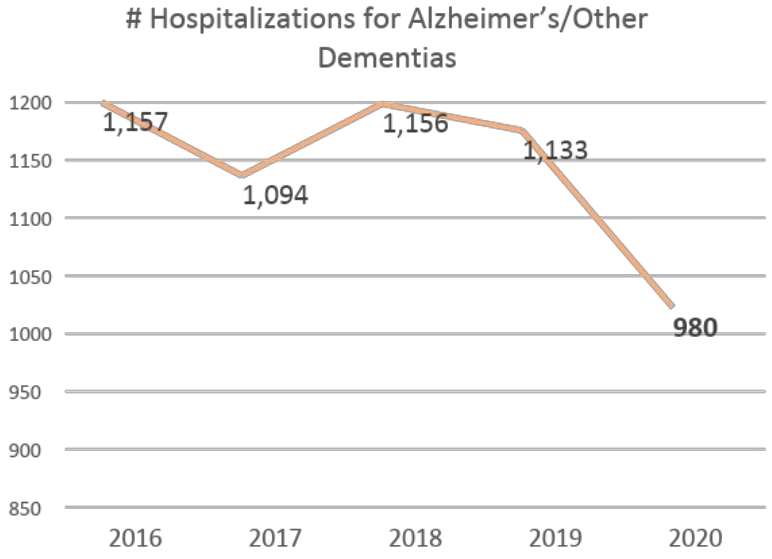


Lowering Obesity and Increasing Physical Activity

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Walk Carroll walking clubs and events, Fitness Fridays, other physical activity events - PHCC • Carroll County Recreation and Parks low-cost classes and new Bicycle and Pedestrian Plan • Low-cost physical activity programming at senior centers - BOAD • Healthy Bites and other nutrition programming - CH • Nutrition programming - PHCC • Promoting Farmers Markets across county • New wellness policy and programming in public schools (child-adolescent obesity) • Maryland Walk Day	• Physical activity opportunities for specific target groups (minorities, low-income, rural areas) • Additional resources for school wellness programs (School Health Council, Mental Health Subcommittee for SHC, NoBody is Perfect, Healthy Carroll Families) • Awareness	• Continue to develop new initiatives through multiagency collaboration – PHCC AHAW LT and HALT • Promote updated wellness policy and programs with school families – CCPS, CCHD, PHCC • Encourage local employers to offer walking or fitness breaks through worksite wellness outreach - PHCC< CCHD • Offer local TOPS chapter for low-cost weight loss • Increase public awareness of resources – PHCC, CCHD, CH, BOAD • Create and promote Wellness Resource Directory – PHCC, CCHD

Older Adult Priorities

Hospitalization for Alzheimer's or Other Dementias



Hospitalizations related to Alzheimer's or other dementias.

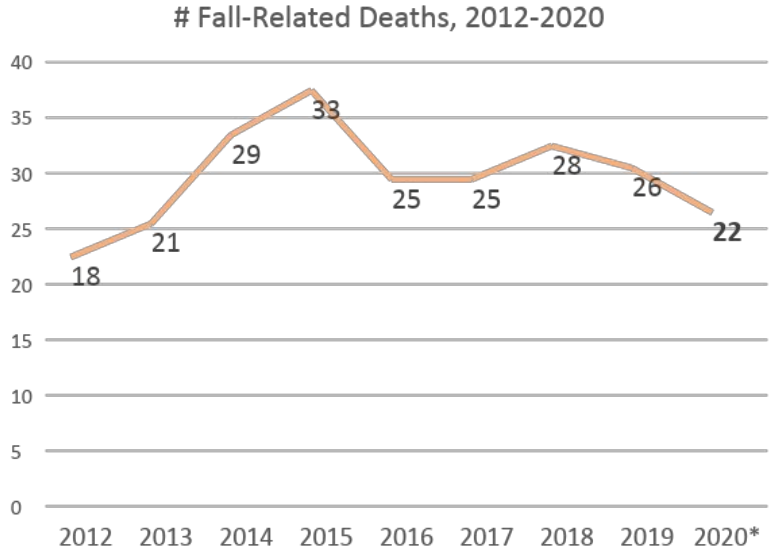
Data Source: Maryland Health Services Cost Review Commission (HSCRC), 2016-2020

SHIP background: In the US, an estimated 5.4 million people are living with Alzheimer's disease. Reducing the proportion of hospitalizations related to Alzheimer's and other dementias can decrease burdens on individuals, families, and the health care system.

As the population continues to age in the county, state, and country, Alzheimer's and other dementia education and resources are becoming increasingly critical. The Partnership's Healthy Aging Leadership Team provides a forum for conversations with our regional Alzheimer's Association and a robust network of elder care providers to help expand local efforts.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Dementia Screening • Alzheimer's Association resources and education • Home Health and Home Care • AERS (Adult Evaluation Review Services)/CFC (Community First Choice) – CCHD • Navigation team at CH (Care Connect Resource Line and Meds Management) • Medical daycares • Occupational Therapy to provide help for individual and caregivers • Caregiver program - BOAD - Financial resources and support group - "Powerful Tools for Caregivers" twice a year (Spring & Fall) - National Family Caregiver Support Program • DSS respite program funding • Assisted livings/long-term care facilities - Memory Care Secured Units available at some facilities across county • Positive Aging Source Book (email) • Virtual conferences/workshops • Guardianship program	• Not clear what next steps should be after screening for dementia • No true list of resources available (i.e. rack card) • Lack of physicians/centers that specialize in Alzheimer's /dementia • Lack of effective medications available • Lack of awareness • Lack of resources impacts provider actions; (reluctance to do memory screenings and of actual diagnosis or what to do after diagnosis) • Dementia screenings in the community • No replacement for memory care program after Copper Ridge shut down	• Create and distribute dementia resource guide -PHCC (HALT) • Raise awareness of dementia screening, next steps, resources - PHCC (HALT) • Screening days - PHCC (HALT)

Fall-Related Mortality



Fall-related deaths

Data Source: Maryland MDH Vital Statistics Administration (VSA), 2012-2020; *2020 data is preliminary

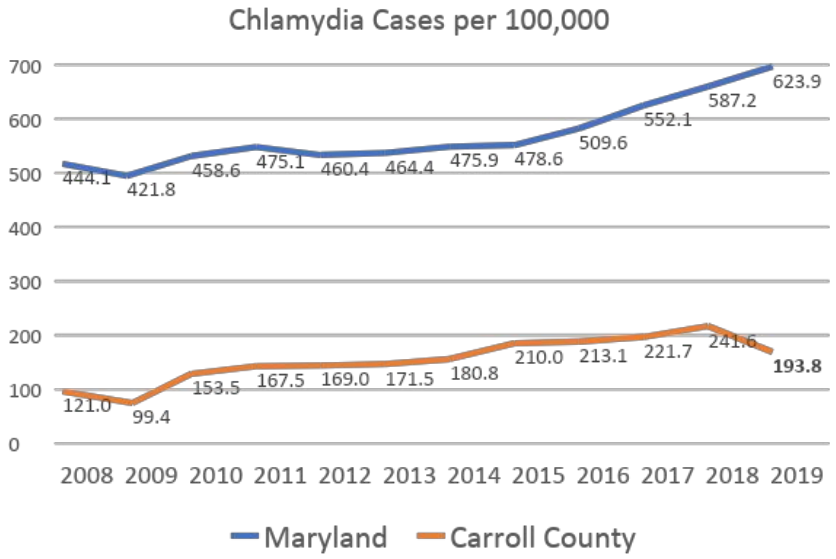
SHIP background: Falls are a major cause of preventable death among the elderly and have increased across age groups in the past decade. Causes of fall-related deaths differ between the elderly and young and middle-aged populations and require different prevention strategies.

Falls prevention has been an ongoing focus for The Partnership's Healthy Aging Leadership Team and the Bureau of Aging and Disabilities. As Carroll County residents age, these effort must be increased to reach this expanding at-risk population.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• Volunteer services to help the elderly - Caring Carroll • Chronic Disease Self Management classes Fall component • Fall Risk Assessment – CCHD (AERS) • Balance screenings, balance stand -- PIVOT PT • Home care/home health • Physical therapy assessment (yearly; Medicare covers) • Healthy U (has fall prevention safety) • Fall Prevention Day - YMCA	• Many areas of county not walkable • Medicare does not cover home care • Having time with physician to do an actual physical assessment • Many people fall but don't identifying the event as an actual fall • Lack of home assessments after being discharged from rehab centers, etc. (home assessments used to occur more in the past, but not as much now because of COVID-19)	• Review data on cause of falls – CCHD LHIC/AHLT • Plan falls prevention demo, screening at Seniors on the Go Expo - PHCC, PIVOT

Other Health Priorities

Chlamydia Rate

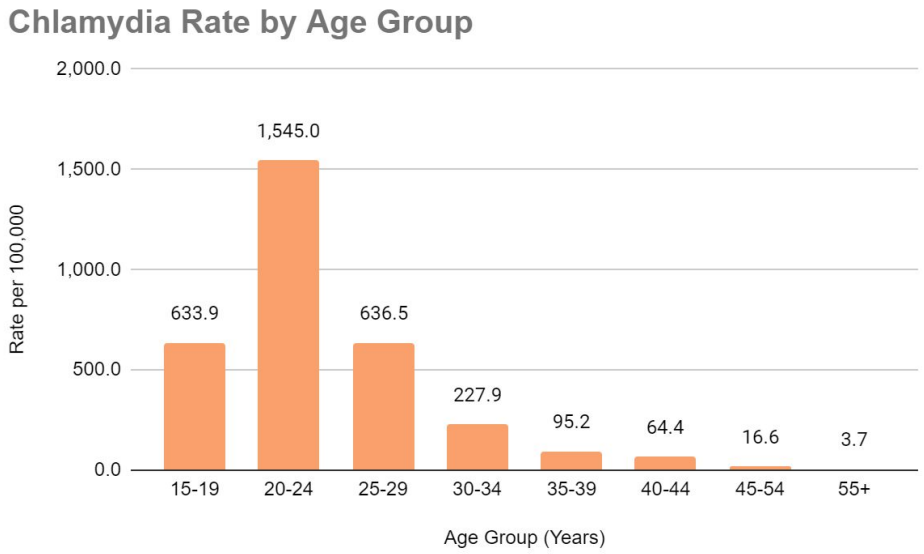


Chlamydia Case Rate per 100,000

Data Source: MDH Prevention and Health Promotion Administration, 2008-2019

SHIP background: Chlamydia is a common STD that can infect both men and women. It can cause permanent damage to a woman's reproductive system. Carroll had one of the highest percent increases of cases in the State but rates have decreased in the last year.

Though Carroll County has a low rate of chlamydia compared to the State, our rates (until 2019) mirror the disturbing upward trend that has been seen across the state and the country.



Chlamydia/STIs, cont.

Current Resources	Gaps/Barriers	Action Steps and Leaders
• 4x/year testing at McDaniel College - CCHD • Walk-in Testing - CCHD • CCHD linking with Detention Center on intake and exit	• Lack of awareness of STI risks for young adults • Lack of awareness of services • Taboo about discussing prevention of STIs • Stigma of seeking help for STIs • Getting tested and to a trusted doctor at a quicker rate • Risk of privacy of young adult if go to doctor that bills insurance (EOBs get mailed to parents' home) • How to have conversations with partners about STIs	• Family Life Curriculum committee – move toward more comprehensive sexual health education, with emphasis on risk reduction – CCPS, CCHS • Raise awareness of issue through community group presentations, health fairs, social media and other outreach – CCHD • Expand availability and awareness of STI/reproductive health services – CCHD, AC